Winter 12-1-2019

They Don't Know I Want to Die: Can Parents Predict Child Suicidality?

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Project

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A Capstone Project submitted in partial fulfillment of the

requirements for the Master of Science Degree in

Counselor Education at

Winona State University

Fall 2019

Winona State University

College of Education

Counselor Education Department

CERTIFICATE OF APPROVAL

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CAPSTONE PROJECT

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They Don't Know I Want to Die: Can Parents Predict Child Suicidality?

This is to certify that the Capstone Project of

Jamie Maston

Has been approved by the faculty advisor and the CE 695 – Capstone Project

Course Instructor in partial fulfillment of the requirements for the

Master of Science Degree in

Counselor Education

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Approval Date: __Dec 7th, 2019__

Abstract

Suicide is a deadly issue that begins with first attempts in childhood and increased rates of subsequent attempts and completions later in life. Parents and school officials are charged with preventing youth suicide, but this is a difficult task. Youth do not communicate their risky behaviors (including suicidal ideation or attempts) with adults leaving the adults to follow other cues to predict suicidality. Parents report much less issues with mental health and suicidality than children and adolescents self-report, and parents' reports are based on externalizing factors as opposed to internalizing factors. Aside from this, there are many reasons that suicidality may not be reported including lack of perceived need, desire and confidence in handling it independently, stigma, lack of confidence in communicating about suicidality, and lack of connections with adults. Many interventions could be implemented in a school setting by counselors including psychoeducation for parents and teachers on signs of suicidality, psychoeducation for students on communication of their own suicidality, and increasing communication with the community and the media on reducing the stigma attached to suicidality to reduce barriers to seeking help.

Keywords: suicide, suicide prevention, children and adolescents, parents

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Suicide was the second leading cause of death among individuals between the ages of 10 and 34 in 2017 (National Institute of Mental Health [NIMH], 2019). In an interview survey of more than 3,200 children ages 12-16, Joffe, Offord, and Boyle (1988) found that 5-10% of boys and 10-20% of girls had suicidal ideation or had made suicide attempts within the last 6 months. In a review of the literature, the prevalence of suicidality in children ages 8-18 can range from 2% if the child is asked if they think *a lot* about killing themselves, to 26% if a child only needs to report one of the following thoughts: thinking life is not worth living, thinking a lot about death and dying, thinking the family will be better off without them, and wishing they were dead, thinking about killing themselves, or thinking a LOT about killing themselves (Velez and Cohen, 1988). Other research puts the number of children with suicidal ideation between 7 and 12% (Kashani, Goddard & Reid, 1989; Thompson et al., 2006; Velez and Cohen, 1988; Walker, Moreau, & Weissman, 1990). Specifically, Velez and Cohen (1988) showed a dramatic increase associated with ages 13-14 and a decline after, likely due to the onset of puberty. In a longitudinal study, researchers found that the majority of suicide attempts were made by young adults who were older than 18 and who had a previous suicide attempt, indicating that first suicide attempts happen in childhood (Velez and Cohen, 1988). Also, suicidality tends to escalate with intent and lethality of means with age, and decreasing time between successive attempts (Goldston et al., 2015). In 2017, suicide rate among adults ages 45 to 54 was the highest among adults of all age groups and adolescents and young adults aged 15 to 24 were second highest (American Foundation for Suicide Prevention [ASFP], 2019). This indicates that prevention and intervention at a younger age would have the highest impact in reducing both first attempts and subsequent attempts.

Adults have been tasked with identifying mental health concerns in their children or in their students (Mayo Clinic Staff, 2018; Walker, et al., 1990), but they may not always know the signs and symptoms of mental illness. Even knowing the signs, it may be difficult for a parent to tell whether this is developmentally typical behavior for a child or if there is something more serious going on. In addition, the stigma attached to mental health may prevent some parents from reaching out to professionals for help (Carpiniello, & Pinna, 2017; Curtis, 2010; Mayo Clinic Staff, 2018).

Children experiencing suicidal ideation will not always clearly express this to a parent or another adult. Young children may lack the ability to verbalize what they are experiencing (Mayo Clinic Staff, 2018; Tishler, Reiss, & Rhodes, 2007) and older children often keep their activities such as drug and alcohol abuse, stealing, or truancy to themselves instead of disclosing. This leads to a discrepancy between what a parent reports of their child's experiences and child self-report of experiences. For example, in a study of Cyberbullying that targeted 1211 adolescents with a mean age of 12.7 years, DeHue, Bolman, & Völlink (2008) found that 16% of students reported having participated in cyberbullying and 23% had been the victim of cyberbullying. However, only 3.3% of these students reported to a parent or caretaker that they had participated in cyberbullying and 9% of students reported to a parent or caretaker that they had been a victim of cyberbullying. The numbers were even lower for reporting to teachers. While many parents set rules for their children regarding use of the internet, they were relatively unaware of their child experiences with cyberbullying either as a victim or perpetrator (DeHue, Bolman, & Völlink, 2008).

Other activities that parents reported as significantly less prevalent than children include carrying a weapon to school, LSD or cocaine use, alcohol, tobacco, and marijuana use, sexual

intercourse, and suicide attempts (Young & Zimmerman, 1998). These other behavioral risk variables also may be related to suicidality. According to the 2014 Ontario Child Health Study, heavy episodic drinking was one factor associated with increased odds of suicidality (Georgiades et al., 2019). More significantly, non-suicidal self-injury, which has more than doubled in prevalence since 2009 (Gardner et al., 2019), had significant relationship with youth who attempted suicide as compared to those who had suicidal ideation alone (Georgiades et al., 2019).

Literature Review

The discrepancy in parent and child reports on activities that parents or society may disapprove of leads to suicidal ideation and other dangers to go unreported, leaving children unable to get professional help. The questions this paper seeks to answer are as follows: How often do parents and children agree on their reports of the child's mental health concerns? Does a parent rate their child's suicidality accurately to the child's self-report? How often is a parent aware their child's suicide attempt(s)? What factors influence how well informed or how intuitive a parent is about their child's suicidality? And, what influences whether or not a child seeks and receives help for their suicidality?

Parent-Child Agreement on Psychiatric Symptoms

Parents and children disagree on the presence and severity of psychiatric symptoms, specifically relating to internalizing and externalizing symptoms (Edelbrock, Costello, Dulcan, Conover, & Kala, 1986; Kashani, et al., 1989). Parents report externalizing symptoms (e.g. acting out, aggression, impulsive behavior) in relation to oppositional disorders and ADHD at a higher rate than their children self-report. However, parents were not as likely to notice their children's internalizing symptoms such as anxiety, fear, obsessions/compulsions, psychotic

symptoms, or emotional disturbances and reported less of these than their child's self-report. (Edelbrock, et al., 1986; Kashani, et al., 1989) Essentially, parents are more cognizant of their children's behavioral symptoms than their affective or neurotic symptoms. Parent child agreement is higher with externalizing symptoms than internalizing, but there is still a discrepancy. Luckily, parent-child agreement is positively correlated with age (i.e. it increases with age) as seen in Edelbrock, et al. (1986) with ages 6-9 ($r=0.10$), ages 10-13 ($r=0.27$), and ages 14-18 ($r=0.35$). Edelbrock, et al. (1986) suggest that neither the parent or the child is right or wrong, but just that they have different perspectives, biases, awareness, sensitivities, and tolerance of certain aspects of behavior and thought.

Children and parents are not completely opposite in recognizing symptoms. Based on the child's self-reports in Kashani et al, (1989), 60% of suicidal children who did not have depression would have been diagnosed with some other disorder suggesting that depression and anxiety are not the only psychopathologies related to suicidal ideation. Joffe, Offord, and Boyle, (1988) found that suicidal behavior in both genders was significantly related to conduct disorder as well as somatization and emotional disorders. Also, in another study looking specifically at mother-child dyads, some mothers showed awareness of more than the child's externalizing symptoms. Mothers of children who had attempted suicide were significantly more likely to report emotional *and* behavioral problems of their child than mothers of non-attempters, and mothers of attempters and were three times as likely to have sought psychiatric help for their kids (Velez & Cohen, 1988). The mothers are aware of a problem even if they do not report the problems the same way as their children do or relate it to suicidality.

Parent-Child Agreement on Suicidality

In several studies, parents noted suicidal ideation at much lower rates than children's self-reports, and teachers noted an even smaller percentage in the same populations (Joffe, Offord, & Boyle, 1988; Kashani et al., 1989; Klaus, Mobilio, & King, 2009; Thompson et al., 2006; Velez and Cohen, 1988; Walker, et al., 1990). In Joffe, Offord, and Boyle (1988) 2.4% parents indicated suicidal behavior in their children, whereas 12.2% of children indicated they had experienced suicidal behavior or ideation. In Kashani et al. (1989), of the 14 children (of 212 studied) who reported suicidal tendencies, only two parents reported this of their child. Thus 86% of parents of suicidal children were not aware. In Velez and Cohen (1988), out of 752 families with children ages 9-18, mother's reported that their children though about death and dying significantly less than their children self-reported. In terms of current suicidal thoughts, youth reported "thinking life is not worth living" at three times the rate that their mother predicted, and youth reported "thinking a lot about death and dying" 40% more than their mothers predicted. Thompson et al. (2006) found that in a sample of more than 1000 child/caregiver dyads, (mean age 8 yrs.), 9.8% of children reported suicidality, while 5.4% of parents predicted child suicidality, and 2.9% of teachers predicted child suicidality. Also, the adults reporting child suicidality and the children self-reporting were inconsistent with each other (i.e. parents who predict suicidality do not have suicidal children, and children who report suicidality do not have parents that predict it). In this case, adults are still consistently underestimating their own child's suicidality and teachers did not fare any better. According to Thompson et al. (2006), "estimates of the prevalence of child suicidality based on child reports was about twice as high as those based on caregiver reports and more than three times as high as those based on teacher reports" (p. 117). More than 75% of the children reporting suicidal ideation were not predicted by their parents and 90% were not predicted by teachers which

means that a large number of children in need of help are likely to go without appropriate treatment. More recently, Klaus et al. (2009) found that 37% of parents were unaware of their children's suicidal ideation and 59% were unaware of their children's suicide plans.

Factors Contributing to Discrepancies

It is important to investigate where these discrepancies in parent and child reports of child suicidal ideation may come from. Perception of the child's symptoms by both parent and child, parental distress, and family issues all may contribute to this. About half of the suicidal children in Kashani, et al. (1989) would be diagnosed with depression based on parental reports of symptoms. Parents also attributed about half of the suicidal children with oppositional symptomology and less than half with anxiety as a symptom complex which is consistent with the research that parents notice externalizing symptoms which the children report more internalizing symptoms.

Caregivers are more likely to report suicidality in their children when they are dealing with their own psychological distress and seeing themselves needing mental health care (Thompson et al., 2006). In some research there is an "indication that depressed parents may be more accurate reporters of their children's feelings (Richters, 1992), and some that they are biased to overreport problems (Brody & Forehand, 1986)" (as cited in Thompson et al., 2006, p. 178). Klaus et al. (2009) found that if either parent had a history of depression, the parents were more likely to be aware of their child's suicidality.

Lastly, there may be social reasons for the disagreement. More than half of children in Walker, et al.'s (1990) study who did not have agreement were diagnosed with substance abuse whereas only 25% of the kids with parental agreement were diagnosed with substance abuse. It is difficult to draw conclusions from one study, but it may suggest that children abusing substances

may be hiding more from their parents or may come from a household with higher disfunction. Parental arrest and family disfunction are significantly related to suicidal behavior (Joffe, et al., 1988). In general, events that decrease the child's feeling that they have familial support is a significant indicator that the parent would be unaware of adolescent reported suicide plans or attempts (Klaus et al., 2009).

Despite a lot of disagreement between caregiver and child reports, there was some agreement. When caregiver and adolescent did agree on suicidality in Thompson et al. (2006) it was associated with mental health needs, aggression, and somatic complaints. Teacher-child agreement was associated with thought problems (e.g. odd or bizarre) and low academic achievement. On the other hand, there were also inconsistencies in which the caregiver reported suicidality and the child did not. Children who did not self-report suicidality but were reported by others still claimed more anger and depression than those who did not self-report suicidality showing that caregivers were observing some symptoms consistent with suicidality. Other characteristics that were common within children that caregivers predicted to experience suicidality include: (1) more caregiver transitions, (2) caregiver-rated child aggressiveness, (3) caregiver-rated child social withdrawal, (4) male child, (5) white child, and (6) caregiver stress. Home may not be the only place where child suicidality is observed. The characteristics of suicidality that were reported by the teachers indicated that students with suicidality tend to be: (1) white, (2) struggling with academic performance issues, and (3) exhibiting thought problems. These teachers were less likely to label African American students suicidal than Whites students (Thompson et al., 2006). Thompson et al. (2006) suggest that it is possible that some children expressed suicidality to their parents or teachers in the past, or it was predicted by them

accurately, but the child failed to disclose suicidality to the interviewer because they did not feel comfortable disclosing to a stranger.

The discrepancies between caregiver and child are not just with suicidal ideation. Disagreement between parent and child reports was also found with parental knowledge of their children's past suicide attempts. In Walker, et al., (1990) more than half the mothers whose children had made suicide attempts did not know about the child's suicide attempt. Eight of the 13 children who reported a suicide attempt did not have a mother who reported it and one mother reported a suicide attempt that was not reported by the child. This is an agreement rate of about 42%. The children whose mothers did not report their suicide attempts reported a lower mean age of first attempt and twice the mean number of attempts as those who did have parental agreement. In Velez and Cohen (1988), only two of the mothers of 25 children who reported at least one suicide attempt were aware or chose to report it. Of the total 40 attempts reported by these children, only four were reported by mothers. This means that 66% of children who attempted suicide have never received any professional help. The authors suggest that the lack of agreement may be caused by underreporting by mothers or overreporting by children. For instance, the mothers or other caregivers think the act was more trivial than a suicide attempt such as believing that taking pills was an accidental overdose or cutting was self-harm as opposed to suicide attempt (Velez & Cohen, 1988). Peers also report that a barrier to seeking help for a friend who has reported suicidal thoughts or self-harm is that they do not believe the person intends to commit suicide (Cigularov, Chen, Thurber, & Stallones, 2008). Klaus et al. (2009) emphasizes that when cutting (or other self-harm) is reported, it is important to understand the true intent of the behavior from the client's perspective as opposed to assuming it is non-suicidal self-harm.

Children and adolescents with more severe depressive disorder symptoms, hopelessness, and, family disfunction are of greatest risk for suicidal behaviors (Hetrick et al., 2011). In clinical setting there was less disagreement between parent and child reports than in community setting. In the clinical setting parents rated their child's depression as more severe which is likely why they got help to begin with (Mokros, Poznanski, Grossman, & Freeman, 1987).

In addition to education, more research is needed to identify factors that lead to denial, exaggeration, or ignorance about child's suicidality on the part of the parents and teachers (Mokros, et al., 1987). Parents may be feeling sadness, anxiety, guilt, or fear in response to their child's suicidality (Greene-Palmer, et al., 2015)

Barriers to Seeking Help

The systematic review of the literature on help seeking behavior found that young people with suicidal ideation or self-harm were more likely to seek help from informal networks such as peers and family; however; overall the rate of seeking help no matter the source was less than 50% (Michelmore & Hindley, 2012). The was less than 30% in other research (Hom, Stanley, & Joiner Jr., 2015). The inconsistent findings may be attributed to demographic differences as well. Women were more likely than men to seek help from a social network whereas men were more likely than women to seek help from emergency services, ethnic minorities were less likely to seek help overall, and lastly, the age was a factor in reporting, where the highest rates of help seeking were found in the older participants studied, at age 26 (Michelmore & Hindley, 2012).

There are many reasons that a person would not seek help when they are experiencing suicidal ideation. Hom, Stanley, & Joiner Jr. (2015) found that choosing not to seek help may be based on lack of perceived need for services, preference for self-management, fear of hospitalization, and structural factors. Interestingly, while much research cites the stigma against

mental health and suicidality as a significant barrier to seeking help (Carpiniello, & Pinna, 2017; Curtis, 2010; Mayo Clinic Staff, 2018), Hom, Stanley, & Joiner Jr. (2015) found that it was less of a significant barrier with only 7-13% of individuals in recent studies stated the stigma as a barrier. This is in comparison to 66% of individuals stating lack of perceived need, and 27% stating they would rather handle it on their own (Czyz et al., 2013; Hom, Stanley, & Joiner Jr., 2015). For younger individuals, barriers include perceived lack of skills needed to communicate suicidality to adults, self-overconfidence, fear of hospitalization, and lack of closeness to school adults (Cigularov, et al., 2008). Also, children who do not feel supported at home are unlikely to report suicidality (Klaus et al., 2009). This is consistent with Cigularov et al. (2008) who found that 43% of adolescents stated that their detachment from adults in the school building was a barrier to them seeking help for suicidal concerns for themselves or a friend.

Some research still points to stigma as a significant barrier to seeking help for suicidality (Carpiniello, & Pinna, 2017; Curtis, 2010; Mayo Clinic Staff, 2018). Carpiniello, & Pinna (2017) found in a narrative review of the topic, that suicidal people are viewed negatively—often labeled as weak or selfish. Individuals who have attempted suicide are distanced socially and even in insurance policies that include clauses excluding death by suicide. Family members of people who have died by suicide also often experience this stigma. In a qualitative study of youth suicide in New Zealand, stigma was one of the main factors reported as a barrier with one respondent stating "it's difficult to say 'you need to see a mental health professional' in a tactful way… it's seen as a weakness. Suggesting it can be a slap in the face" (Curtis, 2010, p 712). The perceived stigma or internalized feelings of shame or embarrassment may lead to a tendency to hide incomplete attempts to protect themselves and their families. This stress may also reduce self-esteem and be a risk factor for future suicide attempts (Carpiniello, & Pinna, 2017).

Parents' decisions can influence help-seeking for their child. Parents of children with anxiety or depressive disorders seek mental health services for their children less often than parents with children with disruptive behavioral disorders because children with anxiety or depressive disorders are perceived as less of a burden (Angold et al., 1998). Much of the research suggests that parent and teachers need education about signs and symptoms of suicidality, depression, and internalizing symptoms (Kashani et al., 1989; Thompson et al., 2006; Young & Zimmerman, 1998). Acting out behavior is more easily detectable by parents as noted earlier in the paper, so educational programs should focus on identifying other types of psychological distress that may be internalized. Also, routine screening is justifiable in high risk populations. Two of the 14 suicidal children in Kashani et al., (1989) did not have any diagnosis which is important to note despite the small sample size because without directly asking, it would be much more difficult to detect.

Hom, Stanley, & Joiner Jr. (2015) found that mental health literacy, positive views of mental health services, and encouragement from family and friends were all related to higher instances of health seeking behaviors. For example, psychoeducational programs such as Surviving the Teens was found to leave students with higher self-efficacy in finding a school adult who they can turn to with suicide related problems and other help seeking intentions (King, Strunk, and Sorter, 2011 as cited in Hom, Stanley, & Joiner Jr., 2015). Peer-training has also been shown to increase positive attitudes toward seeking help from an adult (Kalafat & Elias, 1994; Wyman et al., ac cited in Hom, Stanley, & Joiner Jr., 2015).

Interventions and Applications to School Counseling

As discussed earlier, education for parents, children, peers, and routine screening are ways to help reduce the risk of suicide in youth. These are methods that a school counselor

would be able to implement in their program. Based on the research, there are many options and directions to choose from. Goldston et al. (2015) suggest that there is a severe need for effective prevention programs to reduce the likelihood of a first attempt as well as relapse prevention programs that prevent the escalating cycle of attempts that increase in lethality and decrease in time between consecutive attempts. With parents being unaware of the risk behaviors that their children are involved in and their suicidal ideation and attempts, educating parents of their lack of knowledge may be a first step in gaining their support for school intervention programs such as the Comprehensive School Health Education (CHSE) Program (Young & Zimmerman, 1998). Also, education for parents on how to recognize risks and respond to them with the intention "—not to frighten them, but to enlighten them—" (Young & Zimmerman, 1998, p. 1139) can be helpful. Psychoeducational interventions that emphasize for students how to communicate suicidality would be beneficial since lack of knowledge or lack of comfort communicating suicidality is an issue for youth (Cigularov, et al., 2008). Children may not have the abstract thinking skills to think about the consequences of attempting suicide, and one study suggested that only 25-45% of children express ideation (Shaw, Fernandez, and Rao, 2005 as cited in Tishler, Reiss, & Rhodes, 2007) although the content of the education would differ by age. Promoting protective factors such as sense of connectedness with family (or school adults) and increase coping skills can reduce risk for suicidality could be included (Steele et al., 2018).

Outside of education, Carpiniello, & Pinna (2017) suggest reducing stigma by forming an alliance between scientific societies and the media to continue to reduce the stigma attached to suicide due to the stigma's role in creating a barrier to help seeking and as a potential risk factor for subsequent attempts.

Conclusion and Discussion

Suicide is one of the top three leading causes of death in the pediatric population and a serious public health concern (Ambrose & Prager, 2018) with more than 14% of the population ages 15-24 dealing with suicidality (ASFP, 2019). This issue begins with first attempts in childhood and increased rates of subsequent attempts and completions later in life.

Parents and school officials are charged with preventing youth suicide, but this is a difficult task. Youth do not communicate their risky behaviors (including suicidal ideation or attempts) with adults leaving the adults to follow other cues to predict suicidality. Parents report much less issues with mental health and suicidality than children and adolescents self-report, and parents' reports are based on externalizing factors as opposed to internalizing factors. Aside from this, there are many reasons that suicidality may not be reported including lack of perceived need, desire and confidence in handling it independently, stigma, lack of confidence in communicating about suicidality, and lack of connections with adults.

Many interventions could be implemented in a school setting by counselors including psychoeducation for parents and teachers on signs and for students on communication skills. Also, increasing communication with the community and the media on reducing the stigma attached to suicidality to reduce barriers to seeking help.

There are limitations to this research. There is limited research on children who have died by suicide and limited in all people experiencing suicidality. Due to the barriers of seeking help, the numbers we have may be significantly lower than in reality. Children may underreport their own suicidality, and parents may also report inaccurately either on purpose or due to lack of knowledge—in a society brought up on not talking about mental health, all parties may be denying suicidality because of stigma even if they think it may be true (Mayo Clinic Staff, 2018). Lastly, many studies on suicidality have relatively low number of participants due to the

difficulty of finding suicidal participants, and those who do participate may already be predisposed to talking about their issues.

Future research can be conducted on evaluating interventions for effectiveness. Some research has been done in this area, but it seems that many schools still use the same interventions because that is what they know, or because there is not enough research one way or another on it. Longitudinal data would be helpful in determining the effects of certain psychoeducational, screening, or media communication interventions. We know that the rate of suicide is still increasing, and any number of suicides is too many. Interventions for early prevention of the first possible suicide attempt can help reduce the risk of suicide throughout the lifespan.

Author's Note

Suicide is a tough topic for any counselor, but it is especially scary for a new counselor entering the field. I hope that researching this topic can help me and my colleagues understand how important it is to ask our students about suicidality, create strong connections, and educate others so we can prevent tragic deaths of our students and reduce their suffering.

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